The long road since Claude Bernard

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Claude Bernard (1813–1878) is deemed one of the founding fathers of scientific medicine. With good reason, since he rightly insisted on the necessity of putting knowledge to the test of experiment to discover the causes of biological phenomena and the laws that apply to them. He – rightly too, in my opinion – also uttered very harsh words against medical theories that do not respect the canons of experiment, like magnetism and homeopathy [1]. Since his time, medicine has steadily progressed as a scientific discipline, grounded in biology and chemistry, devising new methods to ascertain the effectiveness of tests and treatments offered to patients. Evidence-based medicine (EBM) is one upshot of the new medical methodology; it is appropriate even when we do not know exactly how substances work in the human body, through which mechanisms they modify our physiology – a very common situation in medicine, due in part to the complexity of biological interactions within our body.

The big successes of scientific medicine – think of vaccines or antibiotics – have nevertheless come with some concerns. Concerns for safety, of course, but these were unavoidable, a by-product of efficacy since any effective substance has – because of its action – some unwanted side effects. This is why we rely on science itself to mitigate them. Regarding other concerns however, science as such was and remains powerless because they are of a normative nature: they are *ethical* concerns. The rise of bioethics in the aftermath of World War II and of several scandals in the USA as well as in Europe is well-known, and this discipline is now firmly established in our medical schools [2]. A perhaps more mundane reason for this rise is the fact that, as Martyn Evans says in his contribution to this issue, medicine is directed towards the patients' *good* and that in a modern pluralistic society, what this good consists of appears to be problematic in numerous situations (think of reasons why a patient might refuse treatment). With the advent of bioethics, several scholars from human and social sciences, such as philosophers, lawyers or theologians, have had a say in medical affairs. Historians were already present, because medicine has always been interested in its history, especially in Germany as Walter Bruchhausen underlines in his paper.

Ethics is a normative discipline; as such, it is distinct from scientific ones that are descriptive (even if they use normative concepts, like health). Nevertheless, if the border between these two kinds of disciplines is conceptually clear, it is fuzzy in reality. In human affairs, facts and values are inextricably intermingled. Moreover, a subjective perspective is inseparable from them. Facts are objective, but ought to be described from a point of view. For norms and values, even if you are a moral realist and believe that values are somewhere in the world, you must concede that they are tied to human desires and personal points of view. Consequently, bioethics cannot set subjectivity aside, all the more because respect for patients' autonomy presupposes consideration of patients' desires and preferences. To take subjectivity seriously is the daily business of clinical ethics, if not of philosophical or «academic» bioethics.

Medical humanities also focus on subjectivity and are interested in life histories – now frequently referred to as «narratives». Humanities – literature, fine arts, anthropology, some trends in philosophy and history (an open-ended list whose length and constituents remain debated) – are well suited to tackle the individual person, but what distinguishes them from medical ethics? It is not an easy question, but I think it possible to shed some light on it in distinguishing three aspects of individuality and generality. When philosophical bioethics deals with individual human beings, it is mainly interested in their *status*; that is, in very general properties that confer moral importance on them: are they persons or not? For clinical ethics, individual human beings are essentially suffering individual patients, each with his/her particular history: they are individuals as *such*. For Medical Humanities, individual human beings are loci and instances of human experiences, able to teach us something *common* to our human condition.

Claude Bernard acknowledged that in medicine, unlike in the other natural sciences, every patient is idiosyncratic. But this was in the – still clinically important – sense that he exemplifies a difference within a type [3]. Through the inclusion of humanities in the medical curriculum and in medicine as a practice, we can measure how long the road has been since his time. With Martyn Evans, we can ask whether medicine should now be considered as *essentially* a technical science or as an existential practice. But maybe essentialism is, here as elsewhere, an unfortunate stance, and we would do better to replace «or» by «and», especially if we think that becoming a physician is a pluridisciplinary business.

The Medical Humanities are important for medicine. They are also important for biomedical ethics; together, they constitute a kind of web. It is a young one, because Medical Humanities have only recently been introduced into the medical curriculum. Laurent Vizier out-

lines how this happened in France and Walter Bruchhausen does the same for Germany; two countries with a different cultural background. Micheline Louis-Courvoisier and Alexandre Wenger, two scholars who have been pioneers in the field in Geneva and in Switzerland, also give their views on the topic. A strong focus, then, for a promising «bioethical» discipline.

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